Columbia Gastroenterology Associates, P.A.

Patient Information Form

LAST NAME | FIRST NAME | MIDDLE | DATE OF BIRTH (mm/dd/yyyy) | SOCIAL SECURITY NUMBER

/ / - -

MAILING ADDRESS | CITY | STATE | ZIP | HOME PHONE NUMBER

( ) -

E-MAIL ADDRESS | CELL PHONE NUMBER

( ) -

MARITAL STATUS (check one):

☐ Married / ☐ Single / ☐ Divorced / ☐ Widowed

SEX (check one):

☐ Male / ☐ Female

RACE (check all that apply):

☐ African American ☐ Asian ☐ Hispanic or Latino

☐ American Indian or Alaska Native ☐ Caucasian ☐ Native Hawaiian or Other Pacific Islander

PREFERRED LANGUAGE:

EMPLOYER | OCCUPATION

BUSINESS ADDRESS | CITY | STATE | ZIP | BUSINESS PHONE NUMBER

( ) -

PRIMARY PHYSICIAN | REFERRING PHYSICIAN

CONTACT PERSON (in case of emergency) | RELATIONSHIP TO PATIENT | PHONE NUMBER

( ) -

RESPONSIBLE PARTY / INSURED PARTY INFORMATION

LAST NAME | FIRST NAME | MIDDLE | DATE OF BIRTH (mm/dd/yyyy) | SOCIAL SECURITY NUMBER

/ / - -

RELATIONSHIP TO PATIENT | OKAY TO RELEASE HEALTH OR FINANCIAL INFORMATION TO THIS PERSON? (check one)

☐ YES ☐ NO

EMPLOYER | BUSINESS ADDRESS | CITY | STATE | ZIP | BUSINESS PHONE NUMBER

( ) -

NOTIFICATION OF PATIENT PRIVACY POLICY: The Health Insurance Portability and Accountability Act (HIPAA) has mandated that all health care providers make available The Notice of Privacy Practices. This Notice is posted in our waiting room for your review. Upon request, a copy of The Privacy Notice will be made available to you. In signing below, you acknowledge that you understand a copy of this office's privacy statement will be available to you should you request it and is available for viewing in this office's waiting room. **PLEASE READ THE POSTED PRIVACY POLICY OR REQUEST A COPY OF THE PRIVACY POLICY.**

SIGNATURE | DATE (mm/dd/yyyy)

I AUTHORIZE THIS OFFICE TO LEAVE MESSAGES PERTAINING TO MY HEALTH CARE OR FINANCES AT THE FOLLOWING PHONE NUMBER(S):

( ) - ( ) -

I AUTHORIZE RELEASE OF MY HEALTH CARE OR FINANCES TO THE FOLLOWING INDIVIDUAL(S):

PRIMARY INSURANCE – COPY OF CARD ATTACHED

NAME OF INSURANCE | POLICY / ID NUMBER | GROUP NUMBER

SECONDARY INSURANCE (if applicable) **–** COPY OF CARD ATTACHED

NAME OF INSURANCE | POLICY / ID NUMBER | GROUP NUMBER

FINANCIAL POLICY: Payment of medical fees is the responsibility of the patient and is due at the time of service. If we are filing your insurance, it is your responsibility to pay us any deductible, co-insurance, or any balance not paid by your insurance company at the time of service. I hereby authorize payment of medical benefits to Columbia Gastroenterology Associates, P.A. for services rendered. I also authorize the release of any medical information to process insurance claims. I acknowledge the responsibility to pay any debt incurred during my treatment.

SIGNATURE | DATE (mm/dd/yyyy)